Form II

TEXAS STATE BOARD OF EXAMINERS OF MARRIAGE AND FAMILY THERAPISTS

VERIFICATION OF LICENSURE IN OTHER JURISDICTION

DIRECTIONS TO APPLICANT: Complete Part I and forward to the state where you hold a license to practice Marriage and Family Therapy.

PART I-TO BE COMPLETED BY THE APPLICANT

Name of Applicant	State from which Verification Requested	License No.	Date Issued

I was granted a license as described above and request that verification of that license be submitted to the Texas State Board of Examiners of Marriage and Family Therapists. You are hereby authorized to release any information in your files, favorable or otherwise, directly to this state's Marriage and Family Therapists Board.

Your early attention is appreciated.

_____

Signature **Date**

PART II-TO BE COMPLETED BY THE STATE BOARD VERIFYING LICENSURE (Please complete this form and return it to the address indicated on the reverse side of this form. Attach copies of any verification of supervision or supervised experience toward LMFT licensure.)

Name of Licensee	Licensure Level	License No.	Date Issued

Hours of supervision and direct supervised clinical experience required for licensure held:

Total hours of supervision: _____ Number of hours of individual supervision:_____

Total hours of practice: _____ Number of hours of direct clinical services: _____

Number of hours of direct clinical services to couples and families: _____

Other requirements:_____

Please Verify Supervision Requirements Met in Your Jurisdiction

Supervision dates: From _____ to _____ Number of months credited _____

Employer name: _____ Employer address:_____

_____ _____

_____

Clinical Supervisor: _____ _____ phone number:_____

Total hours of supervision: _____ Number of hours of individual supervision:_____

Total hours of practice: _____ Number of hours of direct clinical services: _____

Number of hours of direct clinical services to couples and families: _____

Please Verify Supervision Requirements Met in Your Jurisdiction

Supervision dates: From _____ to _____ Number of months credited _____

Employer name: _____ Employer address:_____

_____ _____

_____

Clinical Supervisor: _____ _____ phone number:_____

Total hours of supervision: _____ Number of hours of individual supervision:_____

Total hours of practice: _____ Number of hours of direct clinical services: _____

Number of hours of direct clinical services to couples and families: _____

Please Verify Supervision Requirements Met in Your Jurisdiction

Supervision dates: From _____ to _____ Number of months credited _____

Employer name: _____ Employer address:_____

_____ _____

_____

Clinical Supervisor: _____ _____ phone number:_____

Total hours of supervision: _____ Number of hours of individual supervision:_____
Total hours of practice: _____ Number of hours of direct clinical services: _____
Number of hours of direct clinical services to couples and families: _____

Exam Taken	**Date Exam Passed**	**Exam Score**
_____ **AMFTRB** ____ **Other** (specify)_____		
License Current? ____ **Yes** ____ **No** **Expiration Date** _____	**Complaints and/or Disciplinary Action** _____ **Yes*** _____ **No**	

***Explain Complaints or Disciplinary Actions:**

_____

_____

_____

_____

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_____

Board Seal of State
Board verifying Licensure

_____

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_____

Signature: **Date:**

Name (please type or print)	Title	Telephone No.

Mail To:
Texas State Board of Examiners of Marriage and Family Therapists
P.O. Box 149055
MC-1470
Austin, TX 78714-9055
Phone #: 1-512-834-6657 Fax #: 1-512-834-6677

TEXAS Health and Human Services

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See http://www.hhsc.state.tx.us/ for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

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